

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155674		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/20/2011	
NAME OF PROVIDER OR SUPPLIER ST CHARLES HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 3150 ST CHARLES ST JASPER, IN 47546			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a PSR (Post Survey Revisit) to the Recertification and State Licensure Survey completed on 5/27/11.</p> <p>This visit was in conjunction with a PSR to Complaint IN00088859 and IN 00089054 investigated on 4/29/11.</p> <p>Survey dates: July 19 and 20, 2011</p> <p>Facility number: 002628 Provider number: 155674 AIM number: 200299110</p> <p>Survey team: Terri Walters RN TCP Carole McDaniel RN Martha Sauls RN Elizabeth Harper RN</p> <p>Census bed type: SNF: 12 SNF/NF: 40 Residential: 27 Total: 79</p> <p>Census payor type: Medicare: 16 Medicaid: 20 Other: 43 Total: 79</p> <p>Sample: 9 Supplemental sample: 7 Residential sample: 3</p> <p>St Charles Health Campus was found to be in</p>			{F 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE				TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	Continued From page 1 compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the Rectification and State Licensure Survey. Quality review completed 7/21/11 Cathy Emswiller RN			{F 000}			